Stark Opening Statement At Hearing On Payments To Certain Medicare Fee-For-Service Providers

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Representative Pete Stark (CA-13), Chairman of the Ways and Means Health Subcommittee, delivered the following opening remarks at today's hearing on Medicare payments to hospitals and post-acute providers.

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STARK OPENING STATEMENT AT HEARING ON PAYMENTS TO CERTAIN MEDICARE

FEE-FOR-SERVICE PROVIDERS

WASHINGTON,
D.C. -- Representative Pete Stark (CA-13), Chairman of the Ways and Means Health Subcommittee, delivered the following opening remarks at today's hearing on Medicare payments to hospitals and post-acute providers.

“Mr. Kuhn, Mr. Miller, and industry representatives who are joining us later this afternoon, thank you for coming here today. The focus of today’s hearing is to take a close look at how well Medicare payment systems for hospitals and post-acute providers are working.

“The vast majority of Medicare beneficiaries – nearly 82 percent in 2007 -- receive care within the traditional fee-for-service (FFS) program, rather than in a private plan under Medicare Advantage. Payments under FFS are projected to constitute 71 percent of overall Medicare benefits spending in 2007. It is part of our job to ensure that Medicare is a smart and efficient purchaser of care in both the traditional fee-for-service program and Medicare Advantage.

“As I have said repeatedly this year, no program or payment system, no matter how big or small, is above review. Everything is on the table in terms of refinement and other adjustments.

“Medicare inpatient hospital services are the largest portion of benefit spending, reaching $106 billion in 2006. CMS has recently proposed a regulation that would move forward on MedPAC’s recommendation to modify payments based on severity. I look forward to hearing the details of CMS’s proposals and the hospital industry’s reaction. While adjustments to DRGs along these lines are overdue, I understand that other parts of that regulation may be problematic, and I will return to that issue in a moment.

“In 2006, Medicare spent $43 billion on care provided by post-acute providers, which include skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. These providers serve an important role in ensuring the health of our seniors and people with disabilities. However, the question we have to constantly ask is whether we are providing the right care to the right beneficiary in the right setting at the right price.

“There is dramatic variation in the cost of care, often with little or no evidence that outcomes are better in more costly settings. A guiding tenet for Medicare should be that site of care not be dictated by financial incentives, but rather, by what is best for the patient.

“A further challenge for Medicare is that the four post-acute settings (skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals) act as individual “silos” and do not function as an integrated system. MedPAC and others have highlighted the need for a post-acute assessment tool that guides placement decisions based on the resource needs of the patient, regardless of setting. I hope CMS is making progress in developing a Congressionally mandated demonstration project on this issue and that we hear more about that today.

“CMS has put forth proposals or is implementing various regulations that attempt to better align payment incentives and ensure payment accuracy. I look forward to hearing CMS’s testimony on these regulations. However, we are hearing from industry that many of these regulations – particularly the inpatient hospital regulation – are nothing but “backdoor” attempts to circumvent Congress and cut spending.

“I am loath to intervene in the nuts and bolts of regulations. I usually think that level of detail is best left to the agency, and I recognize that the program needs to make changes to respond to provider behavior. However, a lot of fair questions can be asked about how CMS estimated the possible provider reaction in the inpatient hospital regulation and the magnitude of payment reductions caused by the adjustment.

“Lastly, it boggles my mind that the hospital and post-acute providers would stand silently by while we continue to overpay Medicare Advantage plans. We learned from the CMS Chief Actuary a few weeks ago that these overpayments shorten the life of the Part A Trust Fund by two years. That is two years off of the life of the trust fund where we get the money to pay for inpatient hospital services and most post-acute care.

“Now, the program is not in crisis. We have always done what we needed to in the past to protect Medicare and we will continue to do so. That’s one of the reasons we are having today’s hearing. But it’s important to note that these overpayments directly and negatively affect Medicare’s financial outlook. Last I looked, it’s not as if the plans are treating the hospitals, skilled nursing facilities, or home health agencies well. In fact, I gather payments from the plans often fall short of Medicare’s payment rate under fee-for-service. I hope that the providers who are here today recognize this tension, and will work with us to protect Medicare and ensure its continued strength.”